A Guide To Your Benefits

BlueCross BlueShield of Delaware

Working well together.

bcbsde.com

STATE OF DELAWARE
COMPREHENSIVE PPO PLAN

WELCOME!

This health care plan has been selected by the State Employee Benefits Committee of the State of Delaware. The plan benefits are funded by the State of Delaware and are administered by Blue Cross Blue Shield of Delaware (BCBSD).

This booklet explains your benefits. Please read this booklet carefully and keep it handy.

Use the *Table of Contents* to find topics. A list of terms is given at the back of the booklet.

In this booklet, we sometimes abbreviate terms. For instance:

- **BCBSD** means Blue Cross Blue Shield of Delaware.
- **PPO** means Preferred Provider Organization.

This plan pays only "covered services." See the *Schedule of Benefits* for a list.

This booklet is not a contract. It explains your plan for easy reference. The benefits, terms and conditions of your plan are in an Account Contract on file with the Statewide Benefits Office, Office of Management and Budget. The Account Contract is the final determination of the benefits and rule of your plan.

This booklet explains the benefits in effect as of July 1, 2011. It replaces all previous booklets.

HINTS TO GET THE MOST FROM YOUR HEALTH CARE PLAN

- Always show your ID card when you need care.
- Always follow BCBSD's Managed Care Requirements.
- Read this booklet.
- Information about claims, including Explanation of Benefits (EOBs) are available at **bcbsde.com**.
- Call us if you have any questions!

Remember! If you go to a preferred provider, your benefits are higher.

WHEN YOU HAVE QUESTIONS OR COMMENTS

BCBSD welcomes questions, comments or suggestions. We study your comments to see how we can improve our service. Call or write Customer Service anytime you have a concern about BCBSD's services, procedures or policies. We'll make every attempt to answer your questions and resolve any problems within 30 working days.

Here are reasons you may need to call us:

- asking about your plan
- obtaining information about providers
- reporting a lost or stolen ID card
- ordering a new ID card
- checking on the status of an approval from the Medical Management Department.
- asking about a claim

So that we can learn about our network providers, you may also call or write us when you have a concern about

- access to providers
- the care you received

To Reach Us By Phone

Local Calls: 302.429.0260
Long Distance Calls: 800.633.2563

To talk to a Customer Service Representative, call 8:30 AM to 7:00 PM Eastern Standard Time (EST), Monday through Friday.

You can also get the following information when you call outside the Customer Service Representative hours. Our automated system (VRU) is available Monday through Friday, 24 hours a day, and Saturday until midnight EST for:

- Enrollment information
- Claims status
- Check on managed care approvals
- ID card requests

To Reach Us By Letter

Write to:

Customer Services
Blue Cross Blue Shield of Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

To Reach Us In Person

You may also visit us at several places in New Castle, Kent and Sussex Counties. To find out the days, times and locations, call BCBSD's Customer Service Department.

To Reach Us On The Internet

Internet Address: **bcbsde.com**

To Reach the Medical Management Department (for Managed Care)

Medical Management Department
Blue Cross Blue Shield of Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

Local Calls: 302.421.3333
Long Distance Calls: 800.572.2872

To Reach the Behavioral Health Care Department (for Mental Health and Substance Abuse Managed Care)

Behavioral Health Care Department
Blue Cross Blue Shield of Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

Local Calls: 302.421.2500
Long Distance Calls: 800.421.4577

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COMPREHENSIVE
PREFERRED PROVIDER ORGANIZATION (PPO)
SCHEDULE OF BENEFITS

The next pages describe what's covered under your Comprehensive Preferred Provider Organization (PPO) benefit plan. Please read through these pages to make sure you know what's covered. Knowing what's covered helps you get the most from your health plan.

Many services have limits, copayments, deductibles or coinsurance. Benefits are also subject to the exclusions listed in the section, "What is Not Covered." Benefits and exclusions are described in the next sections. Please read the next sections.

All payments are based on BCBSD's allowable charge. BCBSD determines the allowable charge.

Pre-existing conditions are covered.

Any limits (such as days or dollar amounts) are combined for In-Network and Out-of-Network care. The combined limits determine when you reach the maximum.

DEDUCTIBLE/ COINSURANCE	**IN-NETWORK**	**OUT-OF-NETWORK**
Plan year Deductible	None	$300 per person $600 per family
Plan year Coinsurance Expense Limit	None	$1,500 per person $3,000 per family

Note: For an explanation how Plan Year Deductibles and Plan Year Coinsurance apply to your Out-of-Network benefits, please see the section *Copayments, Deductibles and Coinsurance*, below.

SERVICE	**IN-NETWORK BENEFIT**	**OUT-OF-NETWORK BENEFIT**
Preventive Care		
■ Well Baby Care	$15 Copayment per visit	80% Covered
■ Routine Physical Exams	$15 Copayment per visit	80% Covered
■ Routine Gynecological Exams	$15 Copayment per visit	80% Covered
■ Hemoglobin Tests	$5 Copayment per visit	80% Covered
■ Cholesterol Tests	$5 Copayment per visit	80% Covered
■ Blood Sugar Tests	$5 Copayment per visit	80% Covered
■ Blood Antigen Tests	$5 Copayment per visit	80% Covered
■ Lead Poison Screening Tests	$5 Copayment per visit	80% Covered
■ Lab Charges for Pap Smear	$5 Copayment per visit	80% Covered
■ Blood Occult	$5 Copayment per visit	80% Covered
■ Routine Sigmoidoscopy	100% Covered	80% Covered
■ Colonoscopy	100% Covered	80% Covered
■ Barium Enema	$15 Copayment per visit	80% Covered
■ Routine Mammogram	$15 Copayment per visit	80% Covered
■ Routine Immunizations	$15 Copayment per visit	80% Covered
■ Routine Vision Exams	Not Covered	Not Covered
■ Hearing Exams	100% Covered	80% Covered

SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
Hospital and Other Facility Benefits		
■ Inpatient Hospital	$100 Copayment per day ($200 maximum per admission) then covered at 100%.	80% Covered
■ Surgical Facility Care	100% Covered	80% Covered
■ Skilled Nursing Facility Care	100% Covered; 120 day limit, benefits renew after 180 days without care.	80% Covered; 120 day limit, benefits renew after 180 days without care.
Surgical - Medical Benefits		
■ Surgical Care	100% Covered	80% Covered
■ Anesthesia	100% Covered	80% Covered (covered in-network at network facilities)
■ Inpatient Medical /Consultation Care	100% Covered	80% Covered
■ Organ Transplants	See Benefit Description	See Benefit Description
■ Infertility Services (limited to $10,000 per member's lifetime)	75% Covered	55% Covered; coinsurance does not apply to the coinsurance expense limit
Maternity Benefits		
■ Prenatal and Postnatal Care	100% Covered	80% Covered
■ Inpatient Hospital Care	$100 Copayment per day ($200 maximum per admission) then covered at 100%.	80% Covered
■ Birthing Center	100% Covered	80% Covered
■ Obstetric Care	100% Covered	80% Covered
Emergency Services		
■ Emergency Ambulance and Paramedic Services	100% Covered	100% Covered; no deductible
■ Emergency Facility	$125 Copayment per visit (waived if admitted)	$125 Copayment per visit (waived if admitted)
■ Medical Emergency Care (doctor's care in an emergency facility)	100% Covered	100% Covered; no deductible
Therapeutic and Diagnostic Services		
<u>Outpatient Care</u>		
■ Chemotherapy, Radiation and Inhalation Therapy, Dialysis	100% Covered	80% Covered
■ Physical Therapy	85% Covered.	80% Covered
■ Occupational Therapy	85% Covered.	80% Covered
■ Speech Therapy	85% Covered.	80% Covered
■ Cognitive Therapy	85% Covered for up to 30 consecutive days, beginning on the first day of treatment	80% Covered for up to 30 consecutive days, beginning on the first day of treatment

SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
■ Cardiac Therapy	85% Covered for up to 3 sessions per week and 3 months of treatment	80% Covered for up to 3 sessions per week and 3 months of treatment
■ Lab Tests	$5 Copayment per visit	80% Covered
■ Imaging Services, including MRIs, MRAs, CAT scans and PET scans and nuclear cardiac imaging.	$15 Copayment per visit	80% Covered
■ Machine Tests	100% Covered	80% Covered
<u>Inpatient Care</u>		
■ Therapeutic Services	100% Covered	80% Covered
■ Diagnostic Services	100% Covered	80% Covered
Other Covered Services		
■ Hospice	100% Covered for up to 365 days	80% Covered for up to 365 days
■ Home Health Care	100% Covered for up to 240 visits per plan year	80% Covered for up to 240 visits per plan year
■ Home Infusion	100% Covered	80% Covered
■ Inpatient Private Duty Nursing	100% Covered for up to 240 hours in 12-month period	80% Covered for up to 240 hours in 12-month period
■ Doctor's Home/Office Visits	$15 Copayment per visit	80% Covered
■ Doctor's Nursing Home Visits	100% Covered	80% Covered
■ Specialist/Referral Care	$25 Copayment per visit	80% Covered
■ Diabetic Education (limited to 6 units within a three-year period)	$25 Copayment per visit	80% Covered
■ Nutritional Counseling (limited to 6 visits per condition per plan year)	$25 Copayment per visit	80% Covered
■ Allergy Tests	$25 Copayment per visit	80% Covered
■ Allergy Treatment	$5 Copayment per visit	80% Covered
■ Chiropractic Care	85% Covered for up to 30 visits per plan year	80% Covered for up to 30 visits per plan year
■ Durable Medical Equipment	100% Covered	80% Covered
■ Care for Morbid Obesity		
▪ Office Visits and Labs	See Benefit Description	See Benefit Description
▪ Bariatric Surgery (continued on next page)	Blue Distinction Center for Bariatric Surgery (BDCBS): Facility charges and professional services are covered at the in-network facility benefit level. Non-BDCBS, but in-network: 75% covered.	55% Covered. Coinsurance does not accrue to coinsurance expense limit.

SERVICE	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
▪ Bariatric Surgery (continued)	The 75% coverage level applies for the duration of an inpatient admission, or for all services on the day of an outpatient procedure, and includes: ■ inpatient facility accommodation and ancillary charges ■ outpatient facility and ancillary charges ■ all professional services ■ all diagnostic & therapeutic services. Coinsurance does not accrue to coinsurance expense limit.	
Mental Health Care and Substance Abuse Treatment		
■ Inpatient Hospital Care	$100 Copayment per day ($200 maximum per admission) then covered at 100%.	80% Covered
■ Partial Hospital/Intensive Outpatient Care	100% Covered	80% Covered
■ Office Visits	$15 Copayment per visit	80% Covered

COPAYMENTS, DEDUCTIBLES AND COINSURANCE

In the *Schedule of Benefits*, we refer to copayments, deductibles and coinsurance. These amounts are your share of payment. These terms are described below.

COPAYMENTS

A copayment is an amount you pay at the time you have care. After the copayment, care is paid at 100%. Copayments apply only to certain services. See the *Schedule of Benefits* for a list of services with a copayment.

Here's how copayments work:

- You pay only one copayment to the same provider in the same day.
- If you see more than one provider the same day, you pay copayments to each provider.

Copayments should be paid at the time you receive care.

OUT-OF-NETWORK DEDUCTIBLE AND COINSURANCE EXPENSE LIMITS

Your Out-of-Network benefits have a $300 plan year deductible per person. You must pay the first $300 of allowable charges for services.

You also have a $600 plan year family deductible. This applies when two family members each meet their $300 deductible (totaling $600). Then, no more deductible is taken for all enrolled family members for the rest of the year.

After the deductible is met, most Out-of-Network benefits are paid at 80% of the BCBSD allowable charge. This means the difference of 20% is your coinsurance payment.

Your Out-of-Network benefits have a $1,500 plan year coinsurance expense limit per person. This applies when the coinsurance adds up to $1,500. Then, we pay 100% for the rest of the year. The 100% is based on the BCBSD allowable charge.

You have a $3,000 plan year family coinsurance expense limit. This applies when two enrolled family members each meet their $1,500 coinsurance expense limit (totaling $3,000). Then, we pay 100% for all enrolled members for the rest of the year. The 100% is based on the BCBSD allowable charge.

NOTE: An excess deductible or coinsurance may be taken. This can happen when more than two family members submit claims. Some claims for other family members may have been applied to the deductible or coinsurance before the family limits were met. If you think this has happened, call Customer Service. We'll research your case. If needed, we'll correct your claims.

HOW THE DEDUCTIBLE AND COINSURANCE WORK

Example #1:

Suppose you have Out-of-Network medical expenses of $50.00 in allowable charges. Here's how your Out-of-Network deductible would be reduced:

Your Out-of-Network deductible is $300
Less: Your medical expenses $50
Equals: The amount you still have to pay to meet your Out-of-Network deductible: ...$250

Example #2:

When you meet your deductible, your Out-of-Network benefits are paid at 80% of allowable charges. This means your coinsurance is 20% (100% - 80% = 20%). Suppose you've met your deductible, and have Out-of-Network medical expenses of $500 in allowable charges. Here's how your Out-of-Network coinsurance expense limit is reduced:

Your Out-of-Network coinsurance expense limit is $1,500
Less: Your coinsurance times the medical expenses (20% X $500) $100
Equals: The amount of coinsurance you still have to pay to meet
your Out-of-Network coinsurance expense limit:.....$1,400

When you meet your Out-of-Network coinsurance expense limit, Out-of-Network benefits are paid at 100% of allowable charges for the rest of the plan year.

Example # 3

Except for bariatric surgery, when you use a non-participating provider, benefits are paid at the out-of-network benefit level.

Since the doctor does not participate with the BCBSD, benefits are limited to BCBSD's allowable charge. The amount above BCBSD's allowable charge is your responsibility, and the doctor can balance bill you directly.

Suppose an out-of-network, non-participating surgeon charges $8,000. Since he does not participate with BCBSD, the claim will be subject to the $300 deductible, and the plan will pay 80% of the BCBSD allowable charge:

BCBSD's allowable charge for this service: $2,000
Less your deductible: 300
Equals: 1,700
Less your coinsurance amount (20% x $1700)..... 340
Equals the amount that BCBSD will pay:.....$1,360

Your total liability:
Deductible:.....$ 300
Coinsurance amount: 340
Amount above BCBSD allowable charge for this service:.....6,000
Equals: $6,640

WHAT'S NOT INCLUDED IN THE COINSURANCE EXPENSE LIMIT

The coinsurance expense limit does not include:

- copayments
- deductible amounts
- coinsurance you pay for any in-network service
- coinsurance you pay for artificial reproductive technologies (in-network or out-of-network)
- coinsurance you pay for bariatric surgery (in-network or out-of-network)

CARRYOVER

There is no carryover into a subsequent plan year of any copayments, deductibles, or coinsurance from a previous plan year.

HOW TO USE YOUR COMPREHENSIVE PPO BENEFITS

In this section, we describe how the Comprehensive PPO plan works. Please read these rules carefully. Call us if you have any questions.

TWO LEVELS OF BENEFITS

With the Comprehensive PPO plan, you can receive two levels of benefits:

- With In-Network benefits, your care is covered at the highest level.
- With Out-of-Network benefits, coverage is reduced. The amount you pay is greater.

HOW TO RECEIVE IN-NETWORK BENEFITS

To receive In-Network benefits, see a preferred provider when you need care. The preferred providers are listed in the Provider Network Directory or online at **bcbsde.com. If you receive care without using a preferred provider, your benefits are reduced. This means, your share of payment is greater!**

You must also follow BCBSD's Managed Care Requirements to avoid penalties.

Some preferred providers are not approved by us to give all health services at the In-Network level. For example, a preferred hospital may not be approved as a preferred provider for outpatient lab tests. You should always check the Provider Network Directory before you have care.

HOW TO RECEIVE OUT-OF-NETWORK BENEFITS

With Out-of-Network benefits, you may see any provider you choose. There are higher deductibles and coinsurance. This means your share of payment is greater. **You must also follow BCBSD's Managed Care Requirements to avoid penalties.**

With Out-of-Network benefits, you may choose any provider you wish.

When choosing a provider, there are ways to save money. Many doctors and other providers contract with BCBSD. These providers agree to accept BCBSD's allowable charge as full payment. They are called "participating providers." They cannot bill you more than our allowable charge, even if their normal charge is higher. And, these providers file claims with BCBSD for you. So, you don't need to complete claim forms.

Non-participating providers don't have contracts with BCBSD. They may bill for amounts over our allowable charge. **Be sure to ask if your provider participates with BCBSD.**

EXCEPTIONS TO THE COMPREHENSIVE PPO RULES

Here are some instances when you don't have to use a preferred provider. You'll still get benefits at the In-Network level. Please be careful when you read the following. It's important that you understand the exceptions.

EMERGENCY CARE

If you need emergency care, go to the nearest emergency provider. Benefits will be paid at the same level both In-Network and Out-of-Network, at BCBSD's allowable charge. See the *Emergency and Urgent Care* section for more information.

OUTPATIENT LAB AND IMAGING TESTS

Usually you'll need to go to a preferred lab or imaging provider. However, sometimes a preferred provider will give you a lab or imaging test in the course of other treatment. For example:

- Lab and imaging tests done during outpatient surgery are paid In-Network if the surgical facility is a preferred provider.
- X-rays done for oral surgery are paid In-Network if the surgeon is a preferred provider. See Surgical Benefits to see when oral surgery is paid.
- Lab and imaging tests done as part of hospice or home health care are paid In-Network. These tests must be billed by the provider.
- Imaging done and billed by a preferred orthopedic doctor is paid In-Network.

Use of Provider for Laboratory Services

Effective 2-1-11 BCBSD members, hospitals, and physicians must use the designated network provider of laboratory services for claims to process at the in-network level. As is the case for any service, members may be responsible for the difference between the billed amount and the amount paid by BCBSD when an out-of-network provider is utilized. If a member lives and receives services outside of BCBSD's service area, the local Blue Plan's provider network contract will apply.

OUT OF AREA SERVICES

You can use other Blue Cross Blue Shield provider networks when you have care outside BCBSD's provider area. If you use an Out-of-Area network provider, your benefits will be paid In-Network. When you need out-of-area care, call 800.810.BLUE (800.810.2583) to find out which providers are in the network.

THE BLUECARD® PROGRAM

Follow these five easy steps for health coverage when you're away from home in the United States:

1) Always carry your current BCBSD ID card.
2) In an emergency, go directly to the nearest hospital
3) To find names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder or call BlueCard *Access*® at 800.810.BLUE (800.810.2583).
4) Call BCBSD for pre-certification or prior authorization, if necessary (refer to the phone number on your Blue Plan ID card).
5) When you arrive at the participating doctor's office or hospital, simply present your BCBSD ID card.

After you receive care:

- You should not have to complete any claim forms.
- You should not have to pay up front for medical services, other than the usual out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance)
- BCBSD will send you a complete explanation of benefits.

MANAGED CARE REQUIREMENTS

The benefits provided under this plan are subject to BCBSD's managed care requirements. These requirements are described below, and are administered by BCBSD's Medical Management and Behavioral Health Departments.

Please read these requirements carefully, and call us if you have any questions.

Note: You do **not** need to follow managed care requirements if this plan is secondary (see the section, *Coordination of Benefits).*

AUTHORIZATION FOR HOSPITAL ADMISSIONS – SURGICAL OR MEDICAL

Hospital admissions for surgical or medical care must be authorized by the Medical Management Department. The Medical Management Department can be reached at:

Local Calls: 302.421.3333
Long Distance Calls: 800.572.2872

Emergency Admissions

For emergency admissions, you must call us within 48 hours of admission. If you can't call yourself, your provider, a family member or a friend may call us. BCBSD will review the admission. If approved, we'll assign an initial length of stay.

Maternity Admissions

Maternity admissions don't require BCBSD's prior authorization. However, extended hospital stays must be authorized.

Other Surgical or Medical Admissions

Your doctor should call us at least two weeks before the admission. BCBSD will review your case. From the review, BCBSD may:

- authorize the admission and assign an initial length of stay, or
- not authorize the admission because the admission is not medically necessary. For example, BCBSD may determine your care can be most appropriately provided in an alternative setting.

If these requirements are not followed, BCBSD will deny payment for the hospital charges.

AUTHORIZATION FOR HOSPITAL ADMISSIONS - MENTAL HEALTH OR SUBSTANCE ABUSE

Hospital admissions for mental health or substance abuse care must be authorized by the Behavioral Health Department. The Behavioral Health Department can be reached at:

Local Calls: (302) 421-2500
Long Distance Calls: (800) 421-4577

Emergency Admissions

For emergency admissions, you must call us within 48 hours of admission. If you can't call yourself, your provider, a family member or a friend may call us. BCBSD will review the admission. If approved, we'll assign an initial length of stay and establish a treatment plan.

Planned Admissions

Non-emergency mental health and substance abuse inpatient, partial hospital or intensive outpatient admissions must also be authorized. Your doctor should call us before admission. BCBSD will review your case. From the review, BCBSD may:

- authorize the admission and assign an initial length of stay, or
- not authorize the admission because the admission is not medically necessary. For example, BCBSD may determine your care can be most appropriately provided in an alternative setting.

When a planned admission is authorized, you must use the approved provider and follow the approved treatment plan.

Please notify us as soon as possible, and not later than 30 days after your effective date for this health care plan, if you were receiving care prior to that date. The Behavioral Health Department will work out a transition treatment plan.

If these requirements are not followed, BCBSD will deny payment for the hospital charges.

AUTHORIZATION FOR ADVANCED RADIOLOGY SERVICES

Authorization is required for non-emergency advanced radiology services performed by providers who participate with BCBSD. Some examples of advanced radiology services are CAT and PET scans, MRIs, and MRAs. If these services are not authorized, BCBSD will deny payment and the provider cannot bill you unless:

- BCBSD's authorization requirements were followed, and
- the service was not authorized, and
- having been informed of BCBSD's decision, you chose to have the service anyway, and agreed in writing to be responsible for payment.

If these requirements are not followed, BCBSD will deny payment for all services.

AUTHORIZATIONS FOR OTHER SERVICES

These requirements apply to:

- skilled nursing facility admissions
- home health care
- home infusion

You or the provider must call the Medical Management Department for authorization at least two business days before you begin receiving care. The Medical Management Department reviews the request. If approved, an authorization will be generated that includes the type of service and the number of days or visits initially approved.

If these requirements are not followed, BCBSD will deny payment for all services.

AUTHORIZATIONS TO EXTEND YOUR CARE

Sometimes authorized care will need to be extended. Your provider must call for an authorization to extend your care before the last approved day. BCBSD reviews the request. If authorized, we will assign additional days to the initial approved length of stay and determine when a next review will occur, or will assign additional days for the other services.

If these requirements are not followed, BCBSD will deny payment for the additional days.

CARE MANAGEMENT PROGRAMS

Individual Case Management

BCBSD may provide a case manager to work with you and your doctor to coordinate your care and maximize your existing benefits. The case manager may assist you with:

- coordinating care when you leave the hospital
- providing care in your home
- providing educational materials
- locating network providers
- identifying community services

You may contact the Medical Management Department to request a case manager. BCBSD will evaluate your needs and determine if you meet criteria for case management services. You may choose to decline case management services at any time.

BCBSD may also choose to provide optional benefits not normally included under your plan. These benefits will replace or minimize the need for existing health care plan benefits, and may include modification to copayments, coinsurance, deductibles, limits or covered services. Optional benefits will only be provided as long as they are medically necessary, and the total benefits paid aren't more than the plan benefits. When we provide optional benefits for you, it doesn't mean we need to provide optional benefits for you or anyone else at any other time or in any other situation.

You may accept or reject the optional benefits. If you reject the optional benefits, you are still entitled to benefits under this plan.

USE OF PARTICIPATING PROVIDERS

All providers who participate with BCBSD have agreed to follow BCBSD's managed care requirements. In circumstances where an authorization for a service is required, the participating provider cannot bill you unless:

- BCBSD’s authorization requirements were followed, and
- the service was not authorized, and
- having been informed of BCBSD’s decision, you chose to have the service anyway, and agreed in writing to be responsible for payment.

Non-participating providers may not know about the requirements. It's up to you to call the Medical Management or Behavioral Health Department. If the requirements aren't followed, you may be billed 100% of the charges.

GENERAL CONDITIONS

- BCBSD does not pay for services that are not covered, even when the Medical Management or Behavioral Health Department authorizes them, except for optional benefits authorized by BCBSD through individual case management.
- If you do not comply with the managed care requirements, BCBSD will reduce or deny payment.
- Any payments you must make because you or your provider fail to follow the managed care requirements are not credited toward any deductible or coinsurance requirement.

APPEALS

You may disagree with a decision either the Medical Management or Behavioral Health Department makes. If you disagree, you may file a written appeal with us. See the section, *A Guide To Filing Claims and Appeals,* for more information.

PREVENTIVE SERVICES

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

PREVENTIVE SERVICES

BCBSD promotes preventive care to help you stay well. We administer these benefits according to the BCBSD Preventive Health Guidelines materials. These materials contain details of when we pay for Preventive Care. They are available from BCBSD, or online at **bcbsde.com**. All the terms and conditions of your benefit plan apply to the Preventive Health Guidelines materials.

Please note: BCBSD has the right to change these benefits at any time. Claims for care provided for preventive services submitted with a medical or family history diagnosis are paid at the diagnostic benefit level.

EXAMINATIONS

Benefits are provided for:

- well baby care
- routine physical exam
- routine GYN exam and Pap smear

TESTS AND SCREENINGS

Some examples of covered routine tests, screenings and counseling are:

- blood antigen test for prostate cancer
- blood occult
- blood sugar test
- cholesterol test
- colonoscopy
- electrocardiogram
- flexible sigmoidoscopy
- hemoglobin test
- lead screening
- mammogram
- osteoporosis screening
- alcohol misuse, and tobacco use and tobacco-caused disease counseling
- depression screening for adolescents and adults
- tuberculin testing

ROUTINE IMMUNIZATIONS

Some examples of covered routine immunizations are:

- DTaP and combinations (diphtheria, pertussis, tetanus)
- Hepatitis A
- Hepatitis B
- Hib (haemophilus influenza)
- Influenza
- IPV (polio)
- Meningitis

- MMR (measles, mumps, rubella)
- Pneumococcal
- Td (Tetanus)
- Varicella (chickenpox) vaccine

Immunizations considered by BCBSD to be experimental are not covered.

ROUTINE HEARING EXAMS

Hearing exams are covered as part of a routine physical exam. Visits to a specialist or audiologist are covered under *Specialist Care*.

HOSPITAL AND OTHER FACILITY BENEFITS

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

INPATIENT HOSPITAL CARE

Your care is covered for the following services when you're in the hospital. Please check the *Schedule of Benefits* for any day limits.

Room And Board

Room and board, special diets and general nursing care are covered. Payment is made at the semiprivate room rate. If you have a private room, you pay the extra charge above the semiprivate rate. We cover private rooms only when medically necessary. We also cover intensive care when medically necessary.

Other Hospital Care

When medically necessary, we cover:

- use of operating room and recovery room
- drugs listed in the U.S. Pharmacopoeia or National Formulary
- therapy:
  - chemotherapy by a doctor
  - occupational therapy as called for in your doctor's treatment plan when:
    - needed to help your condition improve in a reasonable and predictable time, or
    - needed to establish an effective home exercise program
  - physical therapy as called for in your doctor's treatment plan when:
    - done by a doctor or licensed physical therapist, and
    - needed to help your condition improve in a reasonable and predictable time, or
    - needed to establish an effective home exercise program
  - radiation therapy for cancer and neoplastic diseases
  - inhalation therapy by a doctor or registered inhalation therapist
  - speech therapy, when:
    - done by a licensed or state certified speech therapist; and
    - ordered by a doctor; and
    - done to improve speech impairment caused by:
      - disease
      - trauma
      - congenital defect, or
      - recent surgery
  - cognitive therapy done by an approved provider. The diagnoses eligible for coverage are:
    - stroke with cognitive impairment, or
    - head injury or trauma.
  - cardiac therapy. Services done on an inpatient and outpatient basis are combined to determine when the limit is met. Services must begin within 4 months following certain serious conditions or procedures.
- surgical dressings
- administration of blood or blood plasma (but not blood itself)
- machine tests

- imaging exams (such as X-rays)
- durable medical equipment
- lab tests
- dialysis

MATERNITY CARE

Hospital and Birthing Center care is covered for:

- pregnancy
- childbirth
- miscarriage

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

This plan conforms with this federal law, which states that group health plans may not restrict mothers' and newborns' benefits for a hospital length of stay related to childbirth to less than:

- 48 hours following a vaginal delivery, and
- 96 hours following a cesarean section.

Maternity lengths of stay may be less than the 48 or 96 hours *only* if both the patient and physician agree.

NEWBORN CARE

Hospital care for a newborn child is covered, provided the child is enrolled.

See the section entitled "A Guide to Enrollment", *Changes in Enrollment (Newborns)* for more information.

OUTPATIENT SURGICAL FACILITY

You're covered for minor surgeries done as an outpatient. Surgeries may be done at:

- hospitals
- approved ambulatory surgical centers

Dental surgery is normally only covered when done in a dentist's or an oral surgeon's office. Dental surgery done in a hospital outpatient department or ambulatory surgical center must be approved by BCBSD. Please refer to the Dental Surgery description in the section entitled *Surgical and Medical Benefits*, below.

EMERGENCY ROOM

You're covered for emergency care in emergency facilities. See the *Emergency and Urgent Care* section for more information.

SKILLED NURSING FACILITY

You're covered for confinement in a skilled nursing facility. BCBSD must approve your stay. We may review your stay every 14 days. A confinement includes all admissions not separated by 180 days. Benefits renew after 180 days without inpatient skilled nursing facility care.

The plan covers:

- skilled nursing and related care as an inpatient
- rehabilitation when needed due to illness, disability or injury

The plan doesn't cover intermediate, rest and homelike care.

SURGICAL AND MEDICAL BENEFITS

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

SURGICAL BENEFITS

Surgical services include:

- cutting and operative procedures
- treatment of fractures and dislocations
- delivery of newborns

These services can be done:

- in hospitals
- in approved ambulatory surgical centers
- at home
- in the doctor's office

The allowable charge includes pre- and post- operative care done by surgeons. We don't pay separate charges for such care.

Dental Surgery

Dental surgery is only covered for:

- extracting bony impacted teeth; or
- correcting accidental injuries (to the jaws, cheeks, lips, tongue, roof and floor of mouth).

Such surgery is covered when done in a dentist's or an oral surgeon's office. Dental surgery done in a hospital outpatient department or ambulatory surgical center must be approved by us.

Coverage is not provided for the extraction of normal, abscessed or diseased teeth or for the removal, repair or replacement of teeth damaged due to accidental injuries or disease even if such services are necessary to correct other injuries suffered as a result of accident or disease.

Multiple Surgical Procedures

When one doctor does more than one procedure on a patient in a single day:

- we provide full contract benefits for the procedure with the highest allowable charge, and
- we determine coverage for the other procedures using special rules on multiple surgical procedures.

When a procedure normally done in one stage is done in two or more stages:

- we cover the entire procedure as one stage.

Women's Health and Cancer Rights Act of 1998

This federal law requires coverage of mastectomy-related services, provided in a manner determined in consultation with the attending physician and patient. This coverage includes:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and;
- Treatment of physical complications of the mastectomy, including lymph edemas.

ANESTHESIA

Anesthesiologist services are covered when medically necessary.

ORGAN TRANSPLANTS

This section describes the coverage for the following human organ transplants:

- heart
- lung/lobar lung
- combined heart and lung
- pancreas
- combined pancreas and kidney
- small bowel
- liver
- combined small bowel and liver
- multivisceral
- autologous bone marrow/stem cell
- allogenic bone marrow/stem cell
- kidney

The level of coverage for these transplants depends upon the facility where the transplant is performed:

- Transplants performed at a Blue Distinction Center for Transplant® (BDCT) are covered at the level of the member's inpatient facility benefit for network providers.
  - Any copayments, deductibles, coinsurance and coinsurance expense limits apply.
  - The benefit includes all organ acquisition costs.

- Transplants performed at non-BDCT, but participating hospitals are covered at the out-of-network inpatient or outpatient facility and professional service benefit levels.
  - Any copayments, deductibles, coinsurance and coinsurance expense limits apply.
  - Except for kidney and bone marrow/stem cell transplants, the maximum benefit for organ harvesting and procurement is $10,000 for each cadaveric organ and up to $45,000 for each organ procured from a living donor (including harvesting). Maximums are subject to copayments, deductibles and coinsurance, if any.

- There are no BDCT facilities for kidney transplants. Kidney transplants are covered at the member's benefit plan's facility and professional benefit levels.
  - Any copayments, deductibles, coinsurance and coinsurance expense limits apply. In the absence of an underlying plan coinsurance expense limit, a $10,000 coinsurance expense limit would apply.
  - Allowable charges for harvesting/procurement for kidneys are determined by BCBSD.
  - Living donor costs are limited to $50,000 (not including harvesting).

- Bone Marrow/Stem Cell Transplants are covered at the member's benefit plan's facility and professional benefit level.
  - Any copayments, deductibles, coinsurance and coinsurance expense limits apply. In the absence of an underlying plan coinsurance expense limit, a $10,000 coinsurance expense limit would apply.
  - Allowable charges for donor treatment and harvesting for bone marrow/stem cells are determined by BCBSD.

- Transplants performed at non-participating hospitals are not covered.

- Travel Reimbursement. For transplants that occur at a facility that is located greater than 50 miles from the recipient's home, the following will be covered during the reimbursement period:
  - $150/day limit for reasonable lodging and meals.
  - Ground travel is reimbursed based on the mileage from the recipient's home or temporary lodging to the transplant facility. Reimbursement is calculated using BCBSD's current mileage reimbursement rate.
  - Air travel is reimbursed at the price of the airline ticket (coach class).
  - Tolls and parking incurred while traveling between recipient's home or temporary lodging and transplant facility.
  - There is a $10,000 aggregate limit for all travel costs.

  The reimbursement period begins 5 days prior to a transplant and ends 12 months after the date of transplant. Reimbursement applies to recipient (adult) and one other person. If the recipient is a minor, two adults are covered.

If you have questions about BCBSD's organ transplant policy, please contact the Medical Management Department at the number listed in the front of this booklet.

INFERTILITY SERVICES

Artificial Insemination (AI) and Intrauterine Insemination (IUI)

AI and IUI procedures are covered when done as an outpatient. The following limits apply:

- dependent children aren't eligible for infertility services
- women must be at least age 18 and not have reached their 45th birthday
- there's a proven infertility problem
- infertility isn't due to voluntary sterilization of either partner

If pregnancy results, your maternity benefits are then applied.

In Vitro Fertilization and related procedures

The following procedures are covered when done as an outpatient:

- In vitro fertilization (IVF)
- gamete intrafallopian transfer (GIFT)
- zygote intrafallopian transfer (ZIFT)

BCBSD must approve your care. Your provider must send BCBSD a completed *Request for IVF Coverage* form, available from bcbsde.com or Customer Service, prior to your beginning treatment.

The criteria listed above for AI and IUI eligibility also apply to IVF and related procedures. In addition, age appropriate AI/IUI procedures must have been previously tried and failed.

Benefit Limits

There's a $10,000 lifetime payment limit for all Infertility Services. The $10,000 limit applies even when you switch to another BCBSD plan. If pregnancy results, your maternity benefits are then applied.

The following are included in the $10,000 maximum.

- all surgical procedures

- office visits
- lab tests
- imaging and machine tests
- hospital services
- anesthesia

Note: Drugs are covered under your prescription drug benefit and are subject to a separate $15,000 limit. Donor services are not covered.

INPATIENT MEDICAL SERVICES

Medical visits by the attending doctor are covered when you're an inpatient. This does not include when you're having surgery. Surgeon pre- and post-operative care is covered under global surgery payment.

We normally cover one doctor visit per day. Usually this is your attending doctor. If another specialist visits you, we may cover the visit, under the following conditions:

- the doctor in charge certifies in writing it's medically necessary,
- the specialist isn't the attending doctor or operating surgeon, and
- the specialist is a doctor.

Only one consultation per specialty per admission is covered.

See the *Mental Health and Substance Abuse Care* section for a description of related doctor visits.

EMERGENCY CARE

You're covered for emergency care in emergency facilities. See the *Emergency and Urgent Care* section for more information.

OBSTETRIC CARE

Obstetric care by doctors and midwives is covered. Coverage is the same as for other surgical and medical care. This includes:

- prenatal care
- anesthesia
- delivery, and
- postnatal care

Midwives are licensed and certified nurses. They must be practicing within the scope of their license. When we cover midwife care, we do not cover a doctor's care for the same services.

One routine ultrasound per pregnancy is also covered.

NEWBORN CARE

Medical care for a newborn child is covered, provided the child is enrolled.

See the section entitled "A Guide to Enrollment", *Changes in Enrollment (Newborns)* for more information.

EMERGENCY AND URGENT CARE

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

EMERGENCY CARE

If you have a life-threatening emergency, go directly to the nearest emergency provider. We cover the emergency facility, ancillary services and physician care when:

- the condition is serious enough to cause a prudent person to seek emergency care,
- a delay in care might cause permanent damage to your health, and
- you have care within 48 hours from the onset of the condition.

Some examples are:

- broken bones
- heavy bleeding
- sudden, severe chest pain
- poisoning
- choking
- convulsions
- loss of consciousness
- severe burns

Mental Heath and Substance Abuse Emergencies

An emergency mental health or substance abuse condition is one which requires voluntary or involuntary hospitalization because the individual patient is a danger to himself or herself, or to others.

COVERAGE FOR EMERGENCIES:

Emergency care is covered for life threatening emergencies only. The facility must be a hospital, or a freestanding emergency facility operating with physicians and nursing personnel on a 24 hour, 7 days per week schedule. You may have a copayment for the emergency facility. The copayment is waived if you're admitted to the hospital directly from the emergency room.

Emergency care is not paid if you didn't have a life-threatening emergency.

EMERGENCY AMBULANCE AND PARAMEDIC SERVICES

Emergency ambulance and paramedic services are covered when:

- a sudden, serious condition requires travel right away, and
- you are taken to the nearest hospital that can treat you.

When you can travel by private car, the ambulance isn't covered. Only one-way travel to the hospital is covered, except when being transported from hospital to hospital for specialized care. In such cases round trip transportation is covered.

Air ambulance is covered only when no other means of travel is appropriate.

When billed separately, these items are not paid:

- patient care equipment
- reusable devices
- first aid supplies

Benefits are not provided when paramedic services are given by state, county or local government.

URGENT CARE FACILITIES/MEDICAL AID UNITS

WHEN YOU'RE HOME

Urgent care is for an injury or sudden illness that isn't life threatening, but you need care within a day or two to avoid a serious problem. For urgent care you can either

- see your regular doctor, or
- seek care at an urgent care facility.

An urgent care facility (also known as a medical aid unit) is a medical facility staffed by physicians and other medical personnel equipped to provide treatment of minor illnesses and injuries of an urgent nature which require prompt, but not emergency treatment.

WHEN YOU'RE TRAVELING

If you're traveling out of state and need urgent care, follow these steps:

Step 1

Find a provider. You can call 800.810.BLUE (800.810.2583) to get connected to a 24-hour referral service. This service helps you find doctors who participate with the local Blue Cross Blue Shield plan where you're traveling. If a doctor is found, you're given the doctor's name, office address and phone number.

You can also use the **bcbsde.com** website to find a provider. The website can access the names, office addresses and phone numbers of network providers nationwide.

Step 2

Call the doctor's office for an appointment and tell them that you're a BCBSD customer. **To get the highest benefit, be sure the provider participates with the local Blue Cross Blue Shield plan.** The doctor's office will check your enrollment. When you receive care, you will be charged the copayment listed on your I.D. card, if any. The doctor's office will then bill the local Blue Cross Blue Shield plan, and the claim will be forwarded to us.

DIAGNOSTIC AND THERAPEUTIC SERVICES

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

INPATIENT DIAGNOSTIC AND THERAPEUTIC CARE

When you're an inpatient, professional care for diagnostic and therapeutic care is covered. See the *Inpatient Hospital Care* section for more information.

OUTPATIENT DIAGNOSTIC AND THERAPEUTIC CARE

DIAGNOSTIC SERVICES

The diagnostic benefits described below apply when you're an outpatient in:

- a provider's office,
- an approved freestanding lab, imaging or machine testing provider, or
- a hospital's outpatient department

Covered care includes:

- imaging services
- lab tests, and
- machine tests

PREADMISSION TESTING

We cover tests done before a scheduled admission for surgery.

Tests must be done

- as an outpatient, and
- within 7 days before the admission

Tests are not covered if

- they are done for diagnosis,
- they are repeated after you enter the hospital, or
- you, not the hospital or physician, cancel or postpone the admission.

THERAPY SERVICES

The therapeutic benefits described below apply when you're an outpatient in:

- a provider's office, or
- a hospital's outpatient department

Covered care includes only:

- chemotherapy by a doctor
- occupational therapy as called for in your doctor's treatment plan when:
  - needed to help your condition improve in a reasonable and predictable time, or
  - needed to establish an effective home exercise program
- physical therapy as called for in your doctor's treatment plan when:
  - done by a doctor or licensed physical therapist, and

  - needed to help your condition improve in a reasonable and predictable time, or
  - needed to establish an effective home exercise program
- radiation therapy for cancer and neoplastic diseases
- inhalation therapy by a doctor or registered inhalation therapist
- speech therapy. Therapy must be:
  - done by a licensed or state certified speech therapist
  - ordered by a doctor, and
  - needed to improve speech problems caused by disease, trauma, congenital defect, or recent surgery
- dialysis
- cognitive therapy done by a provider approved by BCBSD. The diagnoses eligible for coverage are:
  - stroke with cognitive impairment, or
  - head injury or trauma.
- cardiac therapy. Services done on an inpatient and outpatient basis are combined to determine when the limit is met. Services must begin within 4 months following certain serious conditions or procedures.

OTHER COVERED SERVICES

Check the *Schedule of Benefits* for benefit levels and any limits that may apply.
Follow managed care requirements to get the highest benefit!

HOSPICE

Hospice provides palliative and support care to terminally ill patients and their families. BCBSD must authorize the hospice care.

You may have hospice care at home, in an inpatient hospice facility or a short or long term nursing facility.

What Is Covered Under Hospice:

- care by a hospice doctor
- nursing care
- home health aide supervised by a registered nurse
- social service guidance
- nutritional counseling and meal planning
- physical therapy
- speech therapy
- occupational therapy
- spiritual counseling by the hospice
- medical supplies that are needed to manage the illness
- prescription drugs related to the palliative management of the patient's terminal illness
- bereavement counseling for the family for up to 13 months following the death of the patient.

Some services you have during hospice care are not paid under this benefit. They are paid like other covered benefits, such as

- care by a non-hospice doctor
- prescription drugs other than those drugs used for palliative management
- durable medical equipment (DME) not related to palliative management
- palliative chemotherapy or radiation therapy when needed to manage the illness
- inhalation therapy
- imaging and lab tests

If your plan covers these benefits, they will be paid according to the coverage indicated for that specific benefit.

What's Not Covered Under Hospice:

- private duty nursing
- respite care
- care not prescribed in the approved treatment plan
- financial, legal or estate planning, and
- hospice care in an acute care facility, except when a patient in hospice care requires services in an inpatient setting for a limited time.

HOME HEALTH CARE

Home health care is covered. The provider and treatment plan must be approved by BCBSD. Medical records or a suitable summary of the progress of the treatment plan must be reviewed by the attending doctor at regular intervals, or at least every 30 days.

Guidelines:

- Care must be needed to treat or stabilize a condition. Care to maintain a chronic condition is not covered.
- There's a limit of one visit per day per specialty. (A nurse and home health aide count as one specialty for this benefit.)
- Care must be under the direction of a doctor.
- The patient must be home bound and medically unable to get care as an outpatient.
- Care must be in lieu of inpatient care.

What Is Covered Under Home Health:

- skilled nursing care by an RN or LPN
- therapy by licensed or state certified therapists for:
  - physical therapy
  - speech therapy
  - occupational therapy
- medical and surgical supplies
- social service guidance by a licensed or state certified social worker, and
- home health aide when supervised by an RN (limit of 3 visits per week)

What's Not Covered Under Home Health:

- drugs
- lab tests
- imaging services
- inhalation therapy
- chemotherapy and radiation therapy
- dietary care
- durable medical equipment
- disposable supplies
- care not prescribed in the approved treatment plan, and
- volunteer care

HOME INFUSION

Home infusion is home care for receiving needed infusion medicine. It involves the use of an infusion pump with fluids, nutrients and drugs. BCBSD must approve the treatment plan. The plan must be prescribed by a doctor in lieu of inpatient care.

What Is Covered Under Home Infusion:

- nursing care
- medications (includes drug preparation and monitoring)
- solutions, and
- needed infusion pumps, poles and supplies.

What's Not Covered Under Home Infusion:

- delivery costs
- record keeping costs
- doctor management
- other services which do not involve direct patient contact, or
- drugs normally covered under a drug program (whether or not BCBSD provides your drug coverage).

INPATIENT PRIVATE DUTY NURSING

Private duty nursing care is covered when you are an inpatient in an acute hospital. We may review the case in advance. We may review the case again after 80 hours of care. Care must be:

- ordered by the attending doctor
- for the same condition you're hospitalized for, and
- approved by the hospital

This care isn't covered when done in special care units of the hospital, such as:

- self-care units
- selective care units
- intensive care units

This care isn't covered when done as a convenience even if authorized by your doctor.

DOCTOR'S VISITS

Visits with a doctor in the office or your home are covered. This includes visits for injury or illness.

Unless stated on the *Schedule of Benefits*, routine physical exams and tests are not covered.

SPECIALIST/REFERRAL CARE

Home and office visits with specialists are covered.

DIABETIC EDUCATION

Diabetic education provides instruction on the care and treatment of diabetes, including foot care, eye exams for diabetic retinopathy, blood sugar monitoring, medication management and diabetic nutritional counseling. Diabetic education can be performed by either physicians or Certified Diabetic Educators, either on an individual basis or in a group setting.

A diabetic education visit is generally defined as a 30-minute session/unit.

NUTRITIONAL COUNSELING

Services are provided for the assessment and guidance of members at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness. Nutritional counseling is indicated for certain diagnoses, including diabetes, malnutrition, eating disorders and cardiovascular disease.

Nutritional counseling benefits are not provided for weight loss in the absence of co-morbid conditions, or for conditions that have not been shown to be nutritionally related, including, but not limited to, chronic fatigue syndrome and hyperactivity.

ALLERGY TESTING AND TREATMENT

Allergy testing and treatment are covered.

CHIROPRACTIC CARE

The following care is covered when done by a licensed chiropractor for the treatment of spinal conditions:

- office visit for initial evaluation
- manual manipulation of the spine
- ultrasound, traction therapy and electrotherapy

The following limits apply:

- three modalities per visit
- one visit per day

Chiropractic services must either provide significant improvement in your condition in a reasonable and predictable period of time or be necessary to the establishment of an effective maintenance program. Chiropractic services that are part of a maintenance program are not covered.

Chiropractic X-rays are covered only for X-rays of the spine. They are covered under your Outpatient Imaging benefit. You must use a network imaging provider. X-rays by chiropractors aren't covered.

Durable medical equipment (DME) is covered. This includes cervical collars and lumbar sacral supports. These are covered under your DME benefit.

Machine tests are covered under your Therapeutic and Diagnostic Services benefit.

DURABLE MEDICAL EQUIPMENT & PROSTHETICS

Durable Medical Equipment

Covered durable medical equipment (DME) includes items that are:

- prescribed by a doctor, and
- useful to a person only during an illness or injury, and
- deemed by BCBSD to be medically necessary and appropriate.

Some examples of DME are:

- orthopedic braces
- wheel chairs
- orthotics
- hospital beds

We may pay for rent or purchase. If we rent the equipment, our total payment won't exceed the purchase price.

Prosthetics

Covered prosthetics includes items that are

- intended to replace all or part of an organ or body part lost to disease or injury, or absent from birth, or permanently inoperative or malfunctioning
- prescribed by a qualified provider
- removable and attached externally to the body
- deemed by BCBSD to be medically necessary and appropriate

Some examples of prosthetics are:

- hair prostheses for hair loss caused by chemotherapy or alopecia areata resulting from an autoimmune disease
- limb, ear, or eye prostheses
- electro-larynx devices

We also pay to replace or repair prosthetic devices.

We also pay for:

- medical foods and formula for the treatment of inherited metabolic disorders
- hearing aids. Benefits are limited to one hearing aid, per ear, every three (3) years for children less than 24 years of age.

DME & Prosthetics Not Covered:

- items for comfort or convenience
- dental prosthetics
- foot orthotics

CARE FOR MORBID OBESITY

Patients who are overweight and have serious, weight-related diseases, such as hypertension, type II diabetes, and cardiac disease, are considered morbidly obese.

If you are morbidly obese, we cover the following:

- Office visits – payable on the same basis and at the same reimbursement level as other covered outpatient physician visits.
- Laboratory tests - payable on the same basis and at the same reimbursement level as other covered outpatient laboratory services.

Surgical treatment of morbid obesity is covered when certain conditions are met. All such care must be approved by BCBSD.

SURGERY FOR MORBID OBESITY

See the section below, *Blue Distinction Centers for Bariatric Surgery*, for information about how surgery for morbid obesity is paid.

If you are morbidly obese, we cover the following surgical procedures:

- gastric bypass,
- gastric stapling,
- biliopancreatic bypass with duodenal switch and
- gastric banding

- sleeve gastrectomy

You must:

- have achieved full growth and be 18 years or older, and
- have no specific, treatable, correctable cause for the morbid obesity (e.g., endocrine disorder), and
- complete a structured diet program in the 2-year period that immediately precedes the request for the surgery, and
- have received a psychological evaluation specifically for the diagnosis of obesity or morbid obesity,
- have received appropriate medical clearances for the surgery, and
- meet any of the following criteria:
  - you weigh at least 100 pounds above or are twice the ideal body weight; or
  - have a body mass index (BMI) of at least 40 (at least 50 for sleeve gastrectomy); or
  - have a BMI equal or greater than 35, in conjunction with one or more of the following co-morbid conditions: degenerative joint disease, hypertension, coronary artery disease, diabetes, sleep apnea, lower extremity venous/lypmphatic obstruction, obesity related pulmonary hypertension.

Your BMI is calculated by dividing your weight in pounds by your height in inches squared, then multiplying the result by 704.5.

Blue Distinction Centers for Bariatric Surgery (BDCBS)

See the *Comprehensive PPO Schedule of Benefits* for information about benefit levels. You will receive the highest level of benefit for surgery for morbid obesity if you use a BDCBS.

A BDCBS provides a full range of bariatric surgery care services, including inpatient care, post-operative care, outpatient follow-up care and patient education. They have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric patients.

A list of BDCBS can be found at: www.bcbs.com/innovations/bluedistinction/

If you do not use a BDCBS, your benefits will be reduced. See the *Comprehensive PPO Schedule of Benefits* for more information.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Check the *Schedule of Benefits* for benefit levels.
Follow managed care requirements to get the highest benefit!

This plan provides benefits for the treatment of behavioral health disorders, including mental illness and substance abuse. For inpatient, partial hospital and intensive outpatient care, managed care requirements must be followed.

INPATIENT HOSPITAL CARE

Inpatient hospital care is covered on an emergency or planned basis. The following services are covered when you're in the hospital:

Room And Board

Room and board, special diets and general nursing care are covered. Payment is made at the semiprivate room rate. If you have a private room, you pay the extra charge above the semiprivate rate. We cover private rooms only when medically necessary.

Other Hospital Care

When medically necessary, we cover:

- Electroconvulsive therapy by a doctor.
- Detoxification
- Drugs listed in the U.S. Pharmacopoeia or National Formulary
- Lab tests

PARTIAL HOSPITAL CARE

This plan also covers partial hospital programs. A partial hospital program provides an intermediate level of care as an alternative to inpatient hospitalization or as an option following inpatient hospitalization. Partial hospital programs generally are provided within a psychiatric hospital or behavioral health department of a hospital.

INTENSIVE OUTPATIENT CARE

Intensive outpatient care in a free-standing or hospital-based program is covered. Intensive outpatient programs provide a step down from acute inpatient or partial hospitalization, or a step up from outpatient care in office settings.

OUTPATIENT CARE – OFFICE VISITS

Outpatient care covers:

- brief crisis intervention psychotherapy
- psychiatric consultations
- supportive psychotherapeutic treatment, and
- psychological tests (limit of 8 hours of tests per year)

Care must be by a network provider such as a:

- doctor,
- licensed clinical psychologist
- licensed professional counselor of mental health (LPCMH)
- licensed clinical social worker, or
- nurse practitioner.

Care must be done in the provider's office or as a hospital outpatient.

WHAT IS NOT COVERED

The following services and items are not covered.

- Acupuncture.
- Ancillary services (including but not limited to, office visits, physician care, lab and radiology procedures and prescription drugs) in conjunction with a non-covered service.
- Blood, blood components and donor service.
- Care as a result of any criminal act in which you conspired or took part. One example is BCBSD does not pay for the court mandated instruction course or rehabilitation program resulting from driving under the influence of alcohol or drugs.
- Care by:
  - a school infirmary
  - a student health center
  - staff working at the above
- Care for cosmetic reasons.
- Care for complications or consequences of services and items not covered.
- Care for weight loss, unless co-morbid conditions are present.
- Care given by a family member. "Family" means yourself, your parents, your children, your spouse or your siblings.
- Care given by any person living with you.
- Care given by institutions or agencies owned or operated by the government, unless the law requires otherwise. One example is care given by the Veteran's Administration.
- Care given by your employer's health department.
- Care needed through an act of war if the war occurred after this plan became effective.
- Care needed through service in the armed forces of any country.
- Care not directly related to diagnosis or treatment of illness or injury. Care must:
  - be consistent with the symptom or treatment of the condition
  - meet the standard of accepted professional practice
  - not be solely for anyone's convenience
  - be the most appropriate supply or level of care safely provided. For inpatient care, it means care cannot be safely provided as an outpatient.
- Care we consider to be experimental or investigational. Some examples are:
  - care we consider not to be accepted medical practice, and
  - care that requires government agency approval, and the approval hasn't been granted.

  Routine care costs related to approved clinical trials, as determined by BCBSD, are covered.
- Care you can have without charge in the absence of insurance.

- Certain mental health services, including:
  - aptitude tests
  - testing and treatment for learning disabilities
  - treatment for personality disorders
  - care beyond that needed to determine mental deficiency or retardation
  - marital/relationship counseling, and
  - care at behavioral health facilities or in residential programs
- Change of sex surgery, except to correct congenital defect.
- Computerized gait analysis or electrodynographic tests.
- Convenience items. Some examples are:
  - phones
  - TVs
  - radios
  - other personal items
- Dental care, except certain dental care noted in the *Surgical and Medical Benefits* section.
- Drugs or care received in violation of law.
- Enteral nutrition ingested or administered orally, even if it is the sole nutritional source. The only exceptions are certain medical foods prescribed for inherited metabolic disorders.
- Exams or tests done as inpatient for convenience when such care could be done as outpatient.
- Eye or hearing exams, unless noted elsewhere in this booklet.
- Eyeglasses, contact lenses and all procedures for refractive correction.
- Hearing aids for members age 24 and over.
- Immunization or inoculations, unless noted elsewhere in this booklet. Immunizations or inoculations for travel are not covered, except as required by law.
- Injury or illness on the job. One example is any care normally covered under Workers' Compensation or occupational disease laws.
- Items or services that can be purchased without a prescription, unless noted elsewhere in this booklet. Some examples are:
  - Blood pressure cuffs
  - Contraception, first aid and other medical supplies
  - Exercise equipment
  - Incontinence and personal hygiene supplies
- Occupational or physical therapy for developmental delay.
- Orthotic equipment and devices for feet. Some examples are:
  - foot inserts
  - arch supports
  - lifts
  - corrective shoes
- Physical exams, or any other services or treatments required by or intended for:

  - potential employers or licensing authorities (for example, marriage physicals)
  - insurers
  - schools or camps
  - courts or legal representatives
  - any other third party

- Prescription drugs, even if your doctor writes you a prescription.

- Rest cures, custodial care or homelike care even when prescribed by a doctor.

- Routine foot care.

- Services in excess of your covered benefit limits.

- Speech therapy for:
  - attention disorders
  - behavior problems
  - conceptual handicaps
  - learning disabilities
  - developmental delays

- Surgery to reverse voluntary sterilization.

- Thermography.

- Treatment of developmental delay unless there is an identifiable underlying cause.

- Treatment of Temporomandibular Joint (TMJ) Dysfunction Syndrome, unless there is documented organic joint disease, or joint damage resulting from physical trauma. This includes exams for fittings, occlusal adjustment and TMJ devices.

- Vision therapy and orthoptics.

- We cover one service per day by a professional provider. If more than one service is done, we cover only the service with the greater allowable charge.

VALUE ADDED FEATURES

BCBSD offers Value Added Features. They are described below.

Value Added Features are administered only as specified in the BCBSD Value Added Features materials.

Please note: BCBSD has the right to change or discontinue these programs at any time.

EYEWEAR DISCOUNTS

On behalf of BCBSD, your eyewear discount program is administered by Davis Vision, an independent managed vision care company.

You can save money on eyewear by going to one of the program's participating providers. To get a list of participating providers and the products subject to discount, call 888.235.3119 (TTY: 800.523.2847) or visit **www.davisvision.com**.

DISCOUNT PROGRAMS

Valuable discounts on a variety of services are available to BCBSD members. Some of these services are health-related (for example involving fitness, nutrition and weight management as well as alternative therapies and wellness services) and others are not (for example, financial consulting). Health-related discounts include such services as acupuncture, massage therapy, chiropractic care, fitness club memberships, laser vision correction, mail order contact lenses, hearing aids, and eldercare management when receiving care from one of the program's participating providers. For more information on the Discount Programs, please call BCBSD Customer Service or visit our website at **bcbsde.com**.

YOUR RIGHTS AND RESPONSIBILITIES

As a BCBSD member, you have certain rights and responsibilities. Please review them. Please call us if you have any questions.

You have the RIGHT to:

- Be treated with courtesy, consideration, respect and dignity.
- Have your protected health information (PHI) and health records kept confidential and secure, in accordance with applicable laws and regulations.
  - Receive communications about how BCBSD uses and discloses your PHI.
  - Request restrictions on certain uses and disclosures of your PHI.
  - Receive confidential communications of PHI.
  - Inspect, amend and receive a copy of certain PHI.
  - Receive an accounting of disclosures of PHI.
  - File a complaint when you feel your privacy rights have been violated.
- Available and accessible services when medically necessary, including urgent and emergent care 24 hours a day, seven days a week.
- Receive privacy during office visits and treatment.
- Refuse care from specific practitioners.
- Know the professional background of anyone giving you treatment.
- Discuss your health concerns with your health care professional.
- Discuss the appropriateness or medical necessity of treatment options for your condition, regardless of cost or benefit coverage for those options.
- Receive information about your care and charges for your care.
- Receive from your provider, in easy to understand language, information about your diagnoses, treatment options including risks, expected results and reasonable medical alternatives.
- All rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medications and treatment after possible consequences of this decision have been explained to you in your primary language.
- Receive information about BCBSD, its policies, procedures regarding its products, services, practitioners and providers, grievance procedures, and members'/enrollees' rights and responsibilities.
- Play an active part in decisions about your health care including formulating an advance directive.
- Receive benefits and care without regard to race, color, gender, country of origin, or disability.
- File a grievance with BCBSD and receive a response to the grievance within a reasonable period of time.
- Register complaints. This includes requesting an internal appeal or review by an Independent Utilization Review Organization. To register a complaint or request an appeal members are instructed to call the Customer Service number listed on their ID card.
- Submit a formal complaint about the quality of care given by your providers.
- Make recommendations regarding BCBSD's members' rights and responsibilities policies.

You have the RESPONSIBILITY to:

- Double-check that any facilities from which you receive care are covered by BCBSD. Visit bcbsde.com or call the Customer Service number listed on your ID card to ask about a facility.
- Show your ID card to all caregivers before having care.
- Keep your appointments. If you will be late or need to cancel, give timely notice (in accordance with your provider's office policy).
- Treat your providers with respect.
- Provide truthful information (to the extent possible) about your health to your providers. This includes notifying your providers about any medications you are currently taking.
- Understand your health and participate in developing mutually agreed upon treatment goals.
- Tell your health care providers if you don't understand the care he or she is providing.
- Follow the advice of your health care provider for medicine, diet, exercise and referrals.
- Follow the plans and instructions for care that you have agreed on with your practitioners.
- Pay all fees in a timely manner.
- Maintain your BCBSD eligibility. Notify us of any change in your family size, address or phone number.
- Tell BCBSD about any other insurance you may have.

A GUIDE TO ENROLLMENT INFORMATION

WHO IS COVERED

WHO CAN BE COVERED

Your plan may cover:

- You
- Your spouse
- Your children

NOTE: The State of Delaware requires proof of dependency. See the section *Changes in Enrollment*, below, for the documentation required to enroll dependents. BCBSD will require proof of disability through the completion of the *Disabled Child Application* available at bcbsde.com.

TYPES OF ENROLLMENT

You may enroll in one of these coverage types:

- **Employee** for you only
- **Employee and Child(ren**) for you and your children
- **Employee and Spouse** for you and your spouse
- **Family** for you, your spouse and your children

YOU ARE ELIGIBLE TO BE COVERED IF:

- you are a regular officer or employee of the State;
- you are a regular officer or employee of a State agency or school district;
- you are a pensioner already receiving a State pension;
- you are a pensioner eligible to receive a State pension;
- you are a per diem and contractual employee of the Delaware General Assembly and have been continuously employed for 5 or more years;
- you are a regularly scheduled full-time employee of any Delaware authority or commission participating in the State's Group Health Insurance Program;
- you are a regularly scheduled full-time employee of the Delaware Stadium Corporation or the Delaware Riverfront Corporation;
- you are a paid employee of any volunteer fire or volunteer ambulance company participating in the State's Group Health Insurance Program;
- you are a regularly scheduled full-time employee of any county, soil and water conservation district or municipality participating in the State's Group Health Insurance Program;
- you are receiving or eligible to receive retirement benefits in accordance with the Delaware County and Municipal Police/Firefighter Pension Plan with Chapter 88 of Title 11of the Delaware Code or the county and municipal pension plan under Chapter 55A of Title 29 of the Delaware Code.

CHILDREN

To be covered, a child must be

- under age 26, and
- either
  - born to you or your spouse,
  - adopted by you or your spouse, or
  - placed in your home for adoption

Coverage for Other Children

You may also cover a child who is not your or your spouse's natural or adoptive child if the child is:

- unmarried, and
- living with you in a regular parent-child relationship, and
- dependent upon you for support, and qualifies as your dependent under Internal Revenue Code §105 and §152, and
- is under age 19, or
- under age 24 if a full-time student.

You must submit a *Full-Time Student Certification* form at the child's initial eligibility as a full-time student, each time the child's student status changes, and for each school semester. You must also submit a *Statement of Support* form to verify you provide at least 50% support for the child upon enrollment and any time there are changes to the support provided. The forms are available at www.ben.omb.delaware.gov/medical/bcbs or contact your Human Resources/Benefits Office to obtain the forms. The completed forms must be returned to your Human Resources/Benefits Office.

For all children, you are required to show proof of dependency, such as a birth certificate, adoption papers, court order or federal tax return. The applicable documents must be provided to your Human Resources/Benefits Office.

BENEFITS FOR ADULT DEPENDENTS

The Administration of Dependent Coverage to Age 26 policy requires that an *Adult Dependent Coordination of Benefits* form be completed by you on an annual basis at Open Enrollment or anytime throughout the year that the adult dependent's employment or health status changes. See your Human Resources/Benefits Office to obtain the website location of this form, which must be signed by you and provided to your Human Resources/Benefits Office.

This is how we pay benefits for adult dependents enrolled under this Plan:

- We pay normal plan benefits if your adult dependent isn't employed.
- We pay after your adult dependent's plan pays if he/she
  - is eligible for, and
  - **is enrolled** in his/her employer's plan.
- We pay 20% of allowable covered charges if your adult dependent
  - is eligible for, and
  - **is not enrolled** in his/her employer's plan.

The combined payments can't be more than 100% of covered charges. For more details, see the section, *Coordination of Benefits*.

The above will not apply if your adult dependent is not enrolled in his/her employer's plan because he/she

- is less than 21 or turned/turning 21 in the current calendar year, or
- is less than 24 and is a full-time student; or
- does not work full-time; or
- has not satisfied his/her employer's requirement as to the number of hours worked; or
- has to pay an employee contribution of more than 50% of the premium for the lowest health care plan available; or
- does not have employer health care coverage offered by his/her employer.

DISABLED CHILDREN

Disabled children can be covered after the dependent child age limits. They may be covered if:

- they were covered continuously as a dependent child by a group plan through their parent before reaching the dependent child age limit,
- they are not married,
- they have provided 50% or less of their own support because of a disability that is expected to last more than 12-months or result in death,
- their disability occurred before they reached the dependent child age limit,
- they are not eligible for coverage under Medicare, unless federal or state law requires otherwise.

Other rules may apply in the case of divorced parents.

You must file a *Disabled Child Application* form with BCBSD. You may get the form online at **bcbsde.com.**

SPOUSE'S BENEFITS

This is how we pay benefits for spouses enrolled under this Plan:

- We pay normal plan benefits if your spouse isn't employed.
- We pay after your spouse's plan pays if your spouse
  - is eligible for, and
  - **is enrolled** in his/her employer's plan.
- We pay 20% of allowable covered charges if your spouse
  - is eligible for, and
  - **is not enrolled** in his/her employer's plan.

The combined payments can't be more than 100% of covered charges. For more details, see the section, *Coordination of Benefits*.

The above will not apply if your spouse is not enrolled in his/her employer's plan because your spouse

- doesn't work full-time, or
- isn't eligible because he/she doesn't work enough hours to be eligible, or
- isn't eligible because he/she hasn't completed a waiting period, or
- has to pay more than half of the Plan's cost (including flexible credits), or
- doesn't have health coverage at work.

Members are responsible for completing a *Spousal Coordination of Benefits* form each year, or at any time a spouse's job or health coverage status changes. See your Human

Resources/Benefits Office to obtain the website address of the online *Spousal Coordination of Benefits* form.

ENROLLMENT

HOW TO ENROLL

You may enroll yourself and your dependents when you are first eligible or at Open Enrollment by completing the enrollment process as designated by your Human Resources/Benefits Office. If you want to cover your spouse, you'll need to complete the *Spousal Coordination of Benefits Form*. See your Human Resources/Benefits Office to get the enrollment form, application and website address of spousal COB.

HOW TO DECLINE COVERAGE

You may decline coverage if you don't want to enroll when you're first eligible. You will need to complete the enrollment process indicating you are waiving coverage as designated by your Human Resources/Benefits Office.

WHEN COVERAGE BEGINS

When your coverage begins is determined by:

- when you are eligible for coverage, and
- when you enroll for coverage.

There are three categories of enrollees based on when you enroll for coverage. You can be a:

- Timely Enrollee,
- Special Enrollee, or
- Late Enrollee.

TIMELY ENROLLEES

Who Can Be A Timely Enrollee

You are a Timely Enrollee if you enroll within 30 days (31 days for newborns) of when you are first eligible to be covered.

When Coverage Begins

Coverage for new employees (and their dependents) begins

- on the first of the month following the employee's date of hire, or
- on the first of the month following the completion of three months of service when an employee moves to a class that is eligible for health coverage.

SPECIAL ENROLLEES

Who Can Be A Special Enrollee

Please also refer to the section *Changes in Enrollment*, below, for qualifying events that trigger Special Enrollment status.

You are a Special Enrollee if you enroll within the 30-day (31 days for newborns) enrollment period. The enrollment period is measured from the date of the qualifying event, such as:

- losing other health coverage under certain conditions, or

- obtaining a new dependent because of marriage, birth (enrollment period is 31 days, see section below entitled *Changes in Enrollment, Newborns*), adoption or placement in the home for adoption, or court ordered support.

Employees or dependents may qualify as Special Enrollees if the following requirements are met:

- *Employees*: if you're not already enrolled in this Plan, you must:
  - be eligible to enroll in this Plan, and
  - enroll at the same time you enroll a dependent.
- *Spouses and Children*: you're a dependent of an employee:
  - who is already enrolled or is eligible to enroll in this Plan, and
  - who enrolls at the same time you enroll.

If you don't request enrollment within the enrollment period, you are a Late Enrollee.

Loss Of Other Coverage

To qualify as a Special Enrollee because of loss of coverage, you (the employee or dependent) must meet all these conditions:

- you were covered under another group or individual health plan when coverage was previously offered under this Plan (when first eligible or during Open Enrollment), and
- when this Plan was previously offered, you declined coverage under this Plan because you had other coverage, and
- the other coverage was either:
  - COBRA continuation coverage that is exhausted, or
  - other (non-COBRA) coverage that was lost because
    - you are no longer eligible, or
    - the lifetime limits under the other coverage were reached, or
    - the employer stopped contributing, and
- you enrolled within 30 days of the date the other coverage was lost, and
- you can prove the loss of the other coverage by providing proof of coverage, such as a *Certificate of Coverage*.

Special Enrollment Rights for Loss of Medicaid or Children's Health Insurance Program (CHIP) Enrollment

Effective April 1, 2009, you may enroll within 60 days of the date your Medicaid or CHIP coverage was terminated because you were no longer eligible.

New Dependents

You (employee or dependent) are a Special Enrollee if the employee gets a new dependent because of

- marriage,
- birth,
- adoption,
- placement of a child in the home for adoption, or
- court ordered support.

When Coverage Begins

Coverage for Special Enrollees begins as follows. If the Human Resources/Benefits Office was notified of a loss of coverage or new dependent within 30 days and your application and premium is subsequently submitted, coverage begins for:

- *Employees*: the first day of the month after the loss of coverage
- *Spouses*: either the date of marriage or the first day of the month after the marriage
- *Children*: either
  - the date of birth, adoption or placement in the home for adoption; or
  - the first day of the month after you request enrollment if
    - you lost coverage under a prior plan, or
    - your parent got married.

Remember, if you request enrollment after the enrollment period, you (and your dependents) will be Late Enrollees!

LATE ENROLLEES

Who Can Be A Late Enrollee

If you did not enroll as a Timely or Special Enrollee, you are a Late Enrollee. Late Enrollees can enroll at an Open Enrollment period.

Children are Late Enrollees if enrollment was not requested within 30 days of

- birth (31 days),
- adoption,
- placement in the home for adoption, or
- marriage.

When Coverage Begins

Coverage for Late Enrollees begins the first day of the new plan year.

CHANGES IN ENROLLMENT (ALSO SEE *WHEN COVERAGE ENDS*)

You can change your enrollment because of one of the reasons described below. *If added premium is due, you must pay when you enroll.*

You must enroll yourself (and any dependents) within a 30-day period from the dates of the events listed below to be Special Enrollees. You and/or your dependent(s) will be Late Enrollees if you are not enrolled within the 30-day period. Newborns must be enrolled within a 31-day period. See your Human Resources/Benefits Office.

MARRIAGE

You may add your spouse when you get married. You must request enrollment within 30 days after the marriage; a copy of your marriage certificate is required by your Human Resources/Benefits Office. If added premium is due, you must pay when you request enrollment.

Don't forget, when you cover your spouse you'll also need to complete the *Spousal Coordination of Benefits Form.* See your Human Resources/Benefits Office.

You may also add any eligible children or stepchildren when you marry.

DIVORCE

Former spouses aren't eligible for coverage under this program. See the section, *When Coverage Ends*, below for information about disenrolling a former spouse.

NEWBORNS

You may add your newborn child. Coverage for a child born to a regular officer, employee, eligible pensioner or legal spouse will be begin on the date of birth, provided:

- you request enrollment of the child within 31 days of the date of birth, and
- the necessary paperwork, including a valid copy of the child's birth certificate, is provided to the Human Resource/Benefits Office with 31 days of the enrollment request, and
- if applicable, you change your coverage to a type that includes children, and pay any additional premium.

Where an employee has existing coverage that includes children, the 31-day time restriction does not apply, but the child must be enrolled for claims to be paid.

ADOPTED CHILDREN

You may add a child because of adoption or placement in your home for adoption. A birth certificate or legal documentation needs to be supplied to your Human Resources/Benefits Office. You must request enrollment within 30 days of the date the child became eligible.

OTHER CHILDREN

You may add a child other than a newborn or adopted child, such as a step-child. A birth certificate or legal documentation needs to be supplied to your State of Delaware Human Resources/Benefits Office. You must request enrollment within 30 days of the date the child became eligible.

WHEN CONTINUATION OF COVERAGE UNDER COBRA ENDS

You may have declined coverage under this Plan when you were first eligible because you chose to keep COBRA coverage with another plan. If you enroll in this Plan before your COBRA continuation coverage is exhausted, you will be a Late Enrollee.

When your COBRA continuation coverage is exhausted, you may enroll in this Plan.

MEDICARE ELIGIBILITY

At age 65 you become eligible for Medicare. Medicare is provided by the Federal Government. It is not part of this health care plan.

In accordance with the Rule 4.08a of the *State Of Delaware State Employee Benefits Committee Group Health Insurance Plan Eligibility And Enrollment Rules*, an eligible regular officer or employee or a legal spouse (eligible to receive State Share) who reaches age 65 and/or due to disability becomes eligible for Medicare shall continue to be covered under the State Plan as the primary payor of benefits.

- Regular officers or employees and dependents eligible for Medicare, by reason of age or disability, must apply for Medicare Part A when first eligible regardless of their coverage under the State Plan.

- If an employee or dependent covered under the State Plan becomes eligible for Medicare Parts A and B due to End Stage Renal Disease (ESRD), the covered individual must enroll in Medicare Parts A and B and these plans will be primary to the State Plan for the period of time as outlined in the Medicare guidelines.

If you are an active employee working at age 65, you have a choice of benefit plans:

- you can continue coverage in State of Delaware's Group Health Insurance Plan until you retire. This Plan will be primary.
- you can be covered under Medicare. Medicare will be primary. You won't have any other coverage through the State. You can buy Medicare Supplemental coverage directly from BCBSD.

About 3 months before you reach age 65, contact

- your Human Resources/Benefits Office, and
- Social Security Administration Office

Follow the same guidelines when your spouse reaches age 65.

You have to be an active, full-time employee

- to be covered under State of Delaware's Group Health Insurance Plan when you reach age 65.
- for your spouse to be covered under this Plan when he or she reaches age 65.

Please note: If your option is Medicare Supplemental coverage with BCBSD, you must be enrolled in and retain both Parts A and B of Medicare to be eligible for coverage.

HIPAA CERTIFICATE OF CREDITABLE COVERAGE

A federal law called HIPAA requires that the State of Delaware Group Health Plan (the "Plan") provide a Certificate of Creditable Coverage (a "Certificate") to each individual who requests one so long as it is requested while the individual is covered under the Plan or within 24 months after the individual's coverage under the Plan ends. A certificate will also be automatically issued upon the termination of any individuals covered under the Plan, whether or not a request is made. The request can also be made by someone else on behalf of an individual. For example, an individual who previously was covered under this Plan may authorize a new health plan in which the individual enrolls to request a Certificate from this Plan. An individual is entitled to receive a Certificate upon request even if the Plan has previously issued a Certificate to that individual.

Requests for Certificates should be directed to your organization's Human Resources/Benefits Office.

All requests must include:

- The name of the individual for whom the Certificate is requested;
- Where a certificate is requested for a dependent individual, the name of the participant who is enrolled in the Plan; and
- A telephone number to reach the individual for whom the Certificate is requested or the participant who enrolled the individual, in the event of any difficulties or questions.
- The name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- The address to which the Certificate should be mailed; and
- The requester's signature.

After receiving a request that meets these requirements, your organization's Human Resources/Benefits Office will send a request to the State of Delaware COBRA/HIPAA Administrator to provide the Certificate as soon as administratively feasible.

WHEN COVERAGE ENDS

The State of Delaware COBRA Administrator will provide you and your dependents with a standard *Certificate of Coverage* when you lose coverage under this Plan. Also, you have up to 24 months following the loss of coverage to request a certificate. The *Certificate of Coverage* will show how long you were covered under this Plan.

Please read the section, *Continuing your Coverage under COBRA*, to see how you may extend your coverage.

Except in cases of divorce or a change in a child's status (see sections below regarding each), coverage ends the last day of the month in which you lose eligibility because of one of the events below.

DIVORCE

Former spouses are not eligible for coverage under this program. You must notify your Human Resources/Benefits Office of the divorce and provide them with a copy of your divorce decree. An enrollment form/application must be completed within 30 days of the divorce. State "divorce" as the reason for the change.

Coverage ends on the day after the date the divorce is granted.

LEAVE YOUR JOB

Coverage terminates at the end of the month in which you leave your job.

DEATH

Your coverage ends on the day of your death. Coverage ends for your dependents at the end of the month in which you die, except for dependents of pensioners. Coverage for dependents of pensioners ends either:

- the last day of the month of your death, or
- if contributions have already been made, the last day of the following month, or
- when the dependent no longer meets eligibility conditions.

CHANGE IN YOUR JOB STATUS

Coverage ends when you're no longer eligible through your job. This might happen if you begin to work fewer hours, etc. Please refer to the section, *You Are Eligible To Be Covered If*, above.

CHANGE IN CHILD'S STATUS

Unless covered as a disabled child, your child's coverage ends at the end of the month in which he or she reaches:

- 26, if your natural or adoptive child
- age 19, if eligible under the terms described in *Coverage for Other Children*, (see page 41)
- age 24, if similarly eligible and a student (see page 41).

THE PLAN IS CANCELED

Coverage ends the day the State of Delaware's contract with BCBSD ends.

BENEFITS AFTER YOUR COVERAGE ENDS

All benefits end when your coverage ends, except:

- if the State of Delaware cancels its contract with BCBSD, and
- if you are an inpatient on the date the contract ends.

You're covered for the care you receive as an inpatient. The Plan covers you through the earlier of:

- 10 days after the contract ends
- until you are discharged

CONTINUING YOUR COVERAGE UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives you the right to continue your coverage after you lose coverage under this Plan, provided you meet COBRA's definition of a *qualified beneficiary*. If you decide to continue your coverage, you will have to pay up to 102% of the cost of coverage.

The following is a brief explanation of the law:

EMPLOYEE

You (and your dependents) can continue coverage for up to 18 months if you lose group coverage because

- your hours at work are reduced, or
- your job ends (for reasons other than gross misconduct).

You, the employee, can continue coverage beyond 18 months if you:

- are disabled when you become eligible for COBRA coverage, or
- become disabled within the first 60 days of COBRA coverage, and
- are considered disabled by Social Security.

You are then entitled to an additional 11 months (totaling 29 months). Your cost would be 150% of the Plan cost for months 19 through 29.

SPOUSE OF EMPLOYEE

Your spouse can continue coverage for up to 36 months if coverage ends because

- you die,
- you divorce your spouse, or
- you become eligible for Medicare.

DEPENDENT CHILD OF EMPLOYEE

A child can continue coverage for up to 36 months if coverage ends because

- you die,
- you divorce your spouse, or
- you become eligible for Medicare, or

- the child is no longer considered a dependent under this Plan.

NOTIFYING YOUR EMPLOYER

You need to let your Human Resources/Benefits Office know within 30 days of

- a divorce, or
- a child losing dependent status, or
- disability determination by Social Security.

Notify your Human Resources/Benefits Office within 30 days if Social Security determines you are no longer disabled.

Your Human Resources/Benefits Office will have information about COBRA and how much it costs mailed to you. You can choose to continue coverage under COBRA. If you do, then you have the right to the same coverage as the active employees. If you don't, your coverage under this Plan ends.

You should contact State of Delaware's COBRA Administrator if you have any questions. The phone number is: 1-800-877-7994.

WHEN YOUR COVERAGE UNDER COBRA ENDS

You can lose the coverage you continued under COBRA if:

- your employer no longer has any group health coverage,
- you don't pay the premium on time,
- you become eligible for Medicare, or
- you get coverage under another group plan. An exception may apply if the other plan
  - has a preexisting condition waiting period, and
  - provides credit for prior creditable coverage to offset the preexisting condition waiting period.

In such cases, you can be covered under both plans.

You are eligible to receive a standard *Certificate of Coverage* after you lose coverage under COBRA.

DIRECT BILLED PLANS

If your coverage under a group plan with BCBSD ends, you may apply to BCBSD for a direct billed plan. You may also apply for a direct billed plan when COBRA continuation coverage is exhausted.

With a direct billed plan, BCBSD bills you directly for your coverage. BCBSD offers the following types of direct billed plans:

- Medically Underwritten
- Conversion
- Portability

The direct billed plan may have different benefits from your State of Delaware group plan. It may cover fewer items and pay a lower amount. Direct billed plans cover dependent children through December 31 of the year they reach age 26. Dependents over age 26 can apply for a direct billed plan of their own.

MORE ABOUT YOUR DIRECT BILLED PLAN OPTIONS

Medically Underwritten Plans

The following information applies to medically underwritten plans:

- You must apply within 30 days after the group plan ends to avoid a lapse in coverage.
- You cannot be eligible for any other group plan. This applies if you're eligible through your or your spouse's employer or any organization. It applies even if:
  - the other plan has a preexisting condition limit, or
  - the other plan denied your application.
- You cannot be eligible for Medicare.
- You satisfy medical underwriting. After September 23, 2010, applicants under age 19 do not have to satisfy medical underwriting.

There is a 12-month preexisting condition waiting period for the employee and his or her covered dependents. (After September 23, 2010, applicants under age 19 will not be subject to the waiting period.) However, you can get credit for prior coverage under a Blue Cross Blue Shield plan if there is no lapse period between coverage.

Conversion Plans

The following information applies to conversion plans:

- You must apply within 30 days after the group plan ends.
- You cannot be eligible for any other group plan. This applies if you're eligible through your or your spouse's employer or any organization. It applies even if:
  - the other plan has a preexisting condition limit, or
  - the other plan denied your application.
- You cannot be eligible for Medicare.
- There is no medical underwriting.

There is a 12-month preexisting condition waiting period for the employee and his or her covered dependents. (After September 23, 2010, applicants under age 19 will not be subject to the waiting period.) However, you can get credit for prior coverage under a Blue Cross Blue Shield plan if there is no lapse period between coverage.

Portability Plans

The following information applies to the Portability Plans:

- You must have 18 months of prior "creditable coverage."
- You must apply no later than 63 days after the group plan ends.
- You are not eligible if you were most recently covered by a Direct Billed plan or other non-group coverage.
- You cannot be eligible for coverage under Medicare, Medicaid or another group plan.
- You do not have other health insurance coverage.
- Your most recent health insurance coverage was not canceled for your nonpayment of premium or fraud.
- You must have elected and exhausted COBRA continuation coverage available under the group plan.
- Your coverage is not retroactive. The earliest effective date would be the day after you post or deliver your enrollment materials to BCBSD.

There will be no preexisting condition waiting period for the applicant. Eligible family members will get credit toward a 12-month preexisting condition waiting period if there is no lapse period between coverage.

For more information about Direct Billed Plans, call BCBSD's Customer Service department at the number listed in the front of your booklet. If you do not reside in Delaware, you may contact your local Blue Cross Blue Shield plan for more information.

A GUIDE TO FILING CLAIMS AND APPEALS

Always be sure to show your BCBSD ID card when you receive care!

HOW TO FILE CLAIMS

In most cases, claims are filed for you by your provider. This is usually true when you use a **participating provider.**

Always be sure to show your BCBSD ID card when you receive care!

WHEN YOU USE A NETWORK PROVIDER

BCBSD network providers file claims with BCBSD for you. They also accept BCBSD's allowable charge as full payment for covered services. You still pay your share (any copayment, deductible or coinsurance). BCBSD pays network providers for your care.

WHEN YOU USE A NON-NETWORK PROVIDER

Non-Network providers fall into two categories: those who have contracts to participate with BCBSD, and those who do not.

Many doctors and other providers contract with BCBSD. They are called "participating providers". These providers agree to accept BCBSD's allowable charge as full payment. They cannot bill you more than our allowable charge for covered services, even if their normal charge is higher. And, these providers file claims with BCBSD for you. So you don't need to complete claim forms.

Some providers don't have contracts with BCBSD. They may ask you to pay the full cost for your care, and they may bill you for amounts over BCBSD's allowable charge.

If you receive care from a non-participating provider you may need to submit a claim for your care. If the services are covered by BCBSD, we'll pay the allowable charge to you, less any copayment, deductible or coinsurance. This is the same payment we make to participating providers. You must pay any balance over our payment.

WHEN YOU'RE OUT OF AREA

When you receive care in another state, show your BCBSD ID card. Providers participating with the local plan may file your claim with the local plan.

Under the BlueCard® Program:

- you pay any copayment or coinsurance,
- the local plan accepts the provider's claim, and
- payment is made to the provider

IF YOU NEED TO FILE A CLAIM

To obtain a form, call Customer Service. You may also get the form from the BCBSD website, **bcbsde.com**.

Please follow the instructions on the form. Attach an itemized receipt from the provider. Send your claim to this address:

Claims
Blue Cross Blue Shield of Delaware
P. O. Box 8831
Wilmington, DE 19899-8831

HOW TO APPEAL A CLAIM DECISION

You have the right to a full and fair review of all claim decisions. Here's how the appeal process works:

BCBSD'S APPEAL PROCESS

- To appeal a BCBSD decision, you or your representative must contact Customer Service ***within 180 days*** from the date you received the decision. You may call us or you may use the BCBSD Appeal Form on our website, **bcbsde.com.** There is no cost to appeal. Please explain why you believe the decision was wrong and provide any additional relevant information. *If you fail to submit your appeal within the 180-day timeframe, your appeal will be rejected and the initial decision will be upheld.*
- A qualified reviewer, who did not participate in the initial decision, will be appointed to conduct the appeal.
- **Pre-service decision**: For appeals relating to a service you have not received (BCBSD denied authorization and you have not received the service or treatment), you will be notified of the appeal decision within 30 days of your request. You may request an **expedited** appeal for coverage relating to an emergency medical treatment or a life-threatening illness. We will make an expedited appeal decision and notify you and your provider within 72 hours of your request.
- **Post-service decision**: For appeals relating to a service you have already received, you will be notified of the decision within 30 to 60 days of your request for an appeal.

AFTER THE BCBSD APPEAL

- If you have appealed a decision involving medical judgment, experimental or investigational care and are not satisfied with the outcome, you are eligible for an independent review. You must contact BCBSD Customer Service Department in writing within 60 days of the date you received the appeal decision. Please include the appeal decision letter and all pertinent information that supports your request for review. BCBSD will arrange for a review by a medical provider who practices in the same or similar specialty at issue and who has not been involved in the initial decision or the appeal. There is no cost to you for this independent review. You will receive a written decision within 30 to 45 days.
- An expedited review is available if your physician certifies that a delay in receiving the service would jeopardize your health. Expedited reviews are decided within 3 to 5 calendar days after receipt by BCBSD.
- If you request, BCBSD will provide copies of all records relevant to the BCBSD appeal decision.

If you are not sure which of the above processes to follow or would like more information, please call BCBSD Customer Service Appeals Team by one of the methods below.

Internet:

Visit our internet Customer Service Center at **bcbsde.com**.

Telephone:

302.429.0260 northern Delaware
800.633.2563 all other locations
302.421.3411 for the hearing impaired

Mail:

Blue Cross Blue Shield of Delaware
PO Box 8832
Wilmington, DE 19899-8832

COORDINATION OF BENEFITS

BCBSD coordinates payments with any other plan that covers you, your spouse or your dependents. We assure the combined payments don't exceed 100% of the Allowable Expense. This process is described below.

SPOUSAL BENEFITS

We will pay 20% for your spouse's benefits if

- your spouse's employer has a benefit plan, and
- your spouse is eligible, and
- your spouse didn't join the plan.

TERMS

These terms are used to explain the rules for Coordination of Benefits (COB):

- *Allowable Expense* is a necessary, reasonable and usual health care expense. The expense must be covered at least in part by a plan that covers you.
- *COB Provision* sets the order in which plans pay when you're covered by two or more plans.
- *Other Plan* is any arrangement you have that covers your health care.
- *Primary Plan* is the plan applied before any other plan. Benefits under this plan are set without considering the other plan's benefits.
- *Secondary Plan* is the plan applied after the other plan. Benefits under this plan may be cut because of the other plan's benefits.

ORDER OF BENEFITS DETERMINATION

The primary and secondary plan payments are set by these rules:

- A plan with no COB rules is primary over a plan with such rules.
- A plan which covers you as an employee is primary over a plan which covers you as a dependent.
- A plan which covers you as an active employee is primary over a plan which covers you as a non-active employee. Non-active means a laid off or retired employee. This rule also applies if you're the employee's dependent.
- For a child covered by plans under both parents, these rules apply:
  - The plan of the parent whose birthday comes first in the year is primary.
  - If both parents have the same birthday, the plan that covered one parent longer is primary.
  - The other plan's COB rules may set the payment order by the parent's gender. In this case, the male parent's plan is primary.
- If the parents are divorced or separated, this order applies:
  - First, the plan of the parent with custody
  - Then, the plan of the spouse of the parent with custody; and
  - Last, the plan of the parent not having custody.

  This order can change by court decree. A court decree may make one parent responsible for the child's health care costs. If so, that parent's plan is primary.

- If these rules don't decide the primary plan, then the plan covering you longest is primary.
- There may be two or more secondary plans. If so, these rules repeat until this plan's obligation for benefits is set.

EFFECT ON BENEFITS

- When this plan is primary, we pay without regard to any secondary plan.
- When this plan is secondary, we account for payments made by other plans. We'll coordinate with the other plans. We'll make sure payments by all plans don't exceed the Allowable Expenses. Our payment will never be more than if we were primary.
- When this plan is secondary, you don't need authorization from us as long as you follow the primary carrier's managed care requirements. However, if you meet the maximum (either day or dollar) for a particular benefit covered by the primary carrier, you must follow BCBSD's managed care requirements to get the highest coverage under this plan for that particular benefit.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We have the right to decide when to apply COB rules. To do this, we may obtain information as needed. We may also release information to any organization or person as needed.

You must give us the information we need to apply COB rules. This includes information about you and your dependents. If you do not cooperate, we may deny payment.

FACILITY OF PAYMENT

If we're primary, but the other plan paid a claim, we have the right to pay the other plan. Our payment will be the amount we decide is our share under COB rules. Such a payment will meet our obligation under this plan.

RIGHT OF RECOVERY

If we paid more than our share under COB rules, we'll recover the excess from:

- you or any person to or for whom such payments were made
- any insurance plan
- other organizations

BCBSD QUALITY INITIATIVES

BCBSD is committed to offer you quality benefits and services. We have established a clearly defined process to evaluate whether new health care technology and treatments are medically appropriate and supported by sound research.

OUR EVALUATION PROCESS

Our Medical Technology Assessment Committee meets quarterly to evaluate newly proposed technology and treatment benefits. The Committee is made up of

- physicians
- nurses
- health care specialty providers
- senior-level quality administrators

The Committee consults comprehensive, nationally recognized research sources. These sources may include reports from the National Institute of Health, the Journal of the American Medical Association, the New England Journal of Medicine and others as needed.

The Committee uses the following evaluation criteria:

- The technology or treatment must have final approval from the appropriate regulatory body (such as the U.S. Food and Drug Administration).
- The scientific evidence must be conclusive.
- The technology or treatment must improve overall health outcomes. The health improvement must be available outside the investigational setting.
- The technology or treatment must be as good as other established treatment alternatives.
- The technology or treatment must be within the scope of local clinical practice and standards.

Through this process we help make sure that you receive quality health care benefits and services.

CURIOUS ABOUT QUALITY?

BCBSD is proud to share with our members how we work to continuously improve upon the services we offer. We invite you to request copies of BCBSD's quality improvement standards and initiatives by sending a written request to:

Blue Cross Blue Shield of Delaware
Attn: Director of Quality Improvement
P.O. Box 1991
Wilmington, DE 19899-1991

GENERAL CONDITIONS

NOTICE OF GRANDFATHERED STATUS

The State of Delaware Group Health Program believes this First State Basic plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your First State Basic plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Statewide Benefits Office at 1-800-489-8933. You may also contact the U.S. Department of Health and Human Services at **www.healthreform.gov**.

RELEASING NEEDED RECORDS

Your providers have information about you we need to apply benefits. When you applied for coverage, you agreed to let providers give us information we need. This includes the diagnosis and history of your care. This applies to any condition or symptom you had or for which you sought care. It may also include other information. We'll keep these records private as allowed by law.

When you applied for coverage, you authorized us to share records of your health when needed. We'll only share your records to apply your benefits. We may share your records with:

- a medical review board
- a utilization review board or company
- any other health benefit plan
- any other insurance company

If the records relate to fraud or other illegal act, we may disclose them to legal authorities. We may also use them in legal actions.

We may charge a fee for making copies of claim records.

DUAL ENROLLMENT

You may have two or more benefit plans with us. If so, we'll coordinate benefits. However, you may not be enrolled more than once through the State of Delaware.

TIME LIMITS

You must file a claim within 2 years after you receive care. We won't pay a claim filed past the 2 year limit.

DENIAL OF LIABILITY

We're not responsible for the quality of care you receive from a provider. Your coverage doesn't give you any claim, right or cause of action against us based on care by a provider.

NON-ASSIGNABILITY

Any right you have to care is personal and cannot be assigned. Any right you have to payments is personal. Your payment rights cannot be assigned without our written approval.

FINANCIAL RISK DISCLAIMER

BCBSD provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

SUBROGATION

When we pay a claim, we are subrogated to all rights you have against any third party. A third party includes, but is not limited to, another person, legal entity (such as a corporation or self-insured plan), or insurer (providing uninsured or underinsured automobile coverage, other automobile coverage, workers compensation, malpractice, or other liability coverage). We will have the sole right to interpret all rights and duties created by this section.

Some examples of BCBSD's rights include:

- **Constructive trust.** Accepting benefits from BCBSD makes you and your agents a constructive trustee of any funds recovered from any third party. This constructive trust will continue until BCBSD receives payment. Failure to pay funds to BCBSD will be considered a breach of your duty to the health care plan. No settlement can be made without BCBSD's written permission.
- **Subrogation lien.** Accepting benefits from BCBSD will result in an automatic lien by BCBSD against any recovery from any third party. This means BCBSD has the right to first dollar recovery of those funds, whether or not those funds make you whole. First dollar means that BCBSD has first priority to recover from any and all payments made by the third party. Recovery means any judgment, settlement or other obligation to pay money. BCBSD is entitled to recovery from any party possessing the funds.
- **Recovery from a third party.** BCBSD is entitled to be paid from any recovery, no matter how the recovery is categorized. Some examples include recovery for lost wages only or pain and suffering only. You will be responsible for any attorney's fee and costs of litigation.

Some examples of your responsibilities include:

- **Notifying BCBSD.** If you are involved in an accident or incident that results in both BCBSD paying a claim and you having a claim against any third party, you must notify BCBSD in writing within 30 days.
- **Cooperating with BCBSD.** You are required to cooperate with BCBSD and assist in the recovery from the third party.

LEGAL ACTION

There's a 2 year time limit past which you cannot bring legal action against us for not paying a claim. The period begins on the date of service.

POLICIES AND PROCEDURES

To make sure this plan functions as it should, we may adopt any reasonable:

- policies,
- procedures,

- rules, and
- interpretations.

You agree to abide by these rules. If you don't, we may cancel your coverage.

MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACT

We may cancel your coverage if we learn:

- Statements you made when you applied or afterward were untrue or not complete.
- You received or tried to receive benefits under this plan through misrepresentation, fraud or other intentional misconduct.
- You helped someone else in either of the acts noted above.

OUT-OF-AREA SERVICES

BCBSD has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. BCBSD's payment practices in both instances are described below.

BLUECARD® PROGRAM

Under the BlueCard Program, when you access covered healthcare services within the geographic area served by a Host Blue, BCBSD will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

DEFINITIONS

Admission: The time you're an inpatient in a

- hospital
- skilled nursing home
- other facility

The admission runs from the day you're admitted until discharge.

Allowable Charge: The price BCBSD determines is reasonable for care or supplies. See "Allowable Charge Calculations Under the BlueCard Program" in *General Conditions* for more information.

Ambulatory Surgical Centers: Approved outpatient facilities for surgeries.

Birthing Center: Maternity centers that monitor normal pregnancies and perform deliveries.

BCBSD: Blue Cross Blue Shield of Delaware.

Blue Distinction Centers for Bariatric Surgery refers to facilities recognized by the Blue Cross Blue Shield Association to have demonstrated its commitment to quality care, resulting in better overall outcomes for bariatric patients. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations*, including the American Society for Metabolic and Bariatric Surgery (ASMBS), the Surgical Review Corporation (SRC) and the American College of Surgeons (ACS), and is subject to periodic reevaluation as criteria continue to evolve. A list of these facilities may be found at **bcbs.com**.

Blue Distinction Centers for Transplants (BDCT): BDCTs are facilities which participate in a Blue Cross Blue Shield Association transplant program and have demonstrated commitments to quality care, resulting in better overall outcomes for organ transplant patients. A list of these facilities and their transplant programs may be found at **bcbs.com**

Coinsurance: The percent of allowable charges you pay.

Coinsurance Expense Limit: The total amount of coinsurance you pay. When you reach the Limit, our payments increase to 100% of allowable charges. The Limit does not include:

- copayments, if any
- amounts over the allowable charge
- charges for non-covered care

Consultation: An interview or exam by a doctor other than the doctor treating you. The doctor is usually a specialist.

Copayment: The amount you pay at the time of service.

Deductible: The amount you pay before benefits are applied.

Doctor or Physician: A licensed physician, osteopath, podiatrist or dentist. Such a provider must be acting within the scope of his or her license. (Coverage for dental care is limited. See *Surgical and Medical Benefits* and *What Is Not Covered* sections, above.)

Facility: A hospital, skilled nursing home, outpatient care site or like institution.

Hospital:

- *Acute Hospital:* An institution or division of an institution. On an inpatient basis, it primarily provides diagnostic and therapeutic facilities for:

- surgical and medical diagnosis and treatment
- care of obstetric cases

Acute hospitals must be approved by:
- the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
- the American Osteopathic Association (AOA)

Such hospitals charge for their care and receive payments from patients. Facilities and care are supervised or rendered by a staff of licensed doctors. Such hospitals provide 24 hour a day nursing care. The nursing care is under the supervision of registered graduate nurses.

- *Non-Acute Hospital:* An institution that provides care distinct from care usually received in an Acute Hospital. It may be a division, section or part of an Acute Hospital. Non-Acute Hospitals must be approved by:
  - BCBSD
  - the appropriate state or local agency (if required by law)

  Such hospitals charge for their care and receive payments from patients.
- The term **Hospital** does not include the following:
  - nursing homes
  - rest homes
  - health resorts
  - homes for aged
  - infirmaries or places solely for domiciliary care, custodial care, care of drug addiction or alcoholism
  - similar facilities that provide mostly nonmedical services

Imaging: A diagnostic process that shows soft tissue and bones. This includes X-rays, mammograms and magnetic resonance imaging (MRI).

Inpatient: A person in a hospital, skilled nursing home or other facility for an overnight stay.

Machine Test: A test using a device to diagnose a condition. This includes EKGs and EEGs.

Medically Necessary: Care, required to identify or treat a condition, which:
- is consistent with the symptoms or treatment of the condition
- meets the standards of accepted practice
- is not solely for anyone's convenience, and
- is the most appropriate supply or level of care which can be safely provided. For inpatient care, it means the care cannot be safely provided as an outpatient.

Network Provider: A provider with a contract to be a member of BCBSD's preferred network.

Outpatient: A person receiving care while not an inpatient.

Participating Provider: A provider with a BCBSD participating contract. Participating providers will not bill you over the allowable charge for a covered service.

Prescription Drugs: Drugs which are:
- obtained only through a doctor's prescription
- listed in the U.S. Pharmacopoeia or National Formulary, and
- approved by the Food & Drug Administration

Provider: The organization or person giving care, supplies or drugs.

Reopening Period/Open Enrollment Period: The time when you may make changes to your coverage.

Semiprivate Room: A room with at least two beds.

Specialist: A doctor to whom you are referred for care. Sometimes called a *Referral Doctor*.

Specialized Care Facility: A facility for drug and alcohol treatment.

We, Us or Our: Refers to Blue Cross Blue Shield of Delaware.

You and Your: Refers to the employee or any of the employee's eligible dependents enrolled in this plan.

IMPORTANT PHONE NUMBERS AND ADDRESSES

Customer Service:

(For questions about benefits, claims and membership)

Customer Service
Blue Cross Blue Shield of Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

Local Calls: 302.429.0260
Long Distance Calls: 800.633.2563

Medical Management Department:

(For Managed Care)

Medical Management Department
Blue Cross Blue Shield of Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

Local Calls: 302.421.3333
Long Distance Calls: 800.572.2872

Behavioral Health Care Department:

(For Mental Health and Substance Abuse Managed Care Program)

Behavioral Health Care Department
Blue Cross Blue Shield of Delaware
P.O. Box 1991
Wilmington, DE 19899-1991

Local Calls: 302.421.2500
Long Distance Calls: 800.421.4577

Claims:

(For sending in your health care claims)

Claims
Blue Cross Blue Shield of Delaware
P.O. Box 8831
Wilmington, DE 19899-8831

Your Doctor(s):

(Write down your doctors' Names and Phone Numbers for all family members)

Member's Name	Doctor's Name	Phone Number

SG/G-U65-AHP(PPO/HSA PPO/HRA PPO)-1-10
G/SG-U65-AHP(GMF)-1-10
107221-26096
Print Date: 08/01/11